Obstetric Airway Challenges

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KEYWORDS

• Obstetric airway • Human factors • Anaesthesiology • Difficult airway

KEY POINTS

- Obstetric airway management remains high-risk, with a significantly higher incidence of difficult and failed intubation compared to the nonobstetric population.
- Anatomic and physiologic changes in pregnancy, such as airway edema and reduced functional reserve, increase the complexity and urgency of securing the airway.
- Human factors, like stress, communication, and cognitive overload, play a critical role in adverse outcomes during obstetric airway emergencies.
- Improving outcomes requires targeted training, system design, and multidisciplinary teamwork, all grounded in a human factors approach.

INTRODUCTION

Airway management in obstetric anesthesia presents a unique challenge. While neuraxial techniques are now the mainstay of care for caesarean delivery, general anesthesia (GA) remains essential in specific obstetric emergency scenarios, such as severe hemorrhage, acute fetal compromise, or when neuraxial techniques are contraindicated or have failed.[1,2] In these high-pressure situations, the anesthesiologist must rapidly establish a secure airway, often with limited preparation time and amidst significant physiologic and emotional stress.

The incidence of both difficult and failed intubation is markedly higher in obstetric patients. Kinsella and colleagues[3] reported a failed intubation rate of 2.6 per 1000 obstetric general anesthetics (1 in 390), with one maternal death for every 90 failed intubations. Similar data have emerged from Odor and colleagues,[4] who reported a failure rate of 1 in 312, and Quinn and colleagues,[5] at 1 in 224. These figures starkly contrast with those from the general surgical population, where failed intubation rates range from 0.03% (1 in 3333)[6] to as low as 0.0095% (1 in 10,526) in over 860,000 cases.[7]

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Abbreviations	
CLC	closed-loop communication
CS	caesarean section
CTM	cricothyroid membrane
DL	direct laryngoscopy
eFONA	emergency front-of-neck access
FRC	functional residual capacity
GA	general anesthesia
HFNO	high-flow nasal oxygen
NAP4	National Audit Project 4
OAA/DAS	Obstetric Anaesthetists' Association/Difficult Airway Society
SGA	supraglottic airway
VL	videolaryngoscopy

Difficult intubation is also more frequent in obstetrics, with estimates ranging from 1 in 49[8] to 1 in 19[4] compared 1 in 384 to 1 in 212[6,7] in the nonobstetric population.

These statistics, along with the increased risk of aspiration, have contributed to the declining use of GA for caesarean section (CS), which has dropped from 35% in the 1980s[9] to approximately 6% in more recent analyses.[1,10] The infrequency of GA in obstetrics has implications for skill retention and confidence, particularly among trainees. National Audit Project 4 (NAP4)[11] highlighted this concern and emphasized the need for sustained competency through ongoing training and education in obstetric airway management.

While the anatomic and physiologic changes of pregnancy, such as airway edema, increased oxygen consumption, and decreased functional residual capacity (FRC),[12–14] contribute to the difficult airway, human factors are also recognized drivers of adverse outcomes. High-stress environments, time pressure, suboptimal team communication, and cognitive overload all manifest in the obstetric setting. This often happens at the most critical moments. This article explores the obstetric airway through the lens of human factors, examining how systems and individuals interact under pressure, and how improved design, training, and team dynamics can enhance safety.

THE UNIQUE CHALLENGES OF THE OBSTETRIC AIRWAY

Airway management in the obstetric population presents a distinctive set of challenges with a convergence of anatomic, physiologic, situational, environmental, and psychological factors.

Anatomic and Physiologic Challenges

Hormonal changes in pregnancy lead to enhanced vascularity and capillary engorgement of the upper airway mucosa.[12] This results in edema, tissue friability, and congestion, making laryngoscopy more traumatic and increasing the likelihood of bleeding.[12] These changes are compounded by generalized fluid retention and exacerbated by labor-related factors such as oxytocin administration, prolonged Valsalva maneuvers, and intravenous fluid loading.[14–16]

Obesity, prevalent in the obstetric population, adds further complexity. A higher body mass index (BMI) is strongly associated with increased rates of difficult and failed intubation.[5] Anatomic features such as increased neck circumference and enlarged breasts impair optimal positioning for laryngoscopy and increase risk of difficult intubation.[17,18] Pregnant patients also have full dentition, with prominent incisors that may obstruct the view or may pose a risk during intubation.

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Physiologic changes further increase the risks of airway management. FRC decreases by up to 20% due to diaphragmatic elevation,[13] while oxygen consumption increases significantly to meet maternal and fetal metabolic demands.[12] These changes result in a rapid decline in oxygen saturation during apnea, reducing the time available for successful intubation.[19]

Pregnancy also alters gastrointestinal physiology. Increased levels of progesterone relax the lower esophageal sphincter.[20] This combined with the upwards displacement of the stomach by the gravid uterus predisposes the patient to gastric reflux. Pregnancy does not delay gastric emptying, but labor and choice of analgesia may increase residual gastric volume.[21]

Situational Urgency and Limited Preparation

GA in obstetrics is commonly performed in time-critical situations, such as emergency caesarean deliveries or when neuraxial anesthesia has failed.[1,2] These scenarios allow limited time for preoperative assessment, discussion, or equipment checks.[17] Anesthesiologists may meet the patient for the first time immediately before induction, with limited clinical information, heightening the risk of airway complications.

The urgency of these situations increases emotional stress and reduces decision-making time. Physiologic changes of pregnancy, such as reduced FRC and increased oxygen consumption, shorten the time until desaturation during induction of anesthesia.[12–14,19,20] Suboptimal preoxygenation or positioning in these circumstances could increase the likelihood of desaturation and failed intubation.[22,23]

Environmental and Organizational Constraints

Labor ward theaters are often operationally different and located away from the main theater complex. They may have different staffing models and equipment availability compared to a general operating theater with out-of-hours delayed access to senior anesthetic support. Historically, obstetric units often lacked the resources and equipment needed to manage difficult airways effectively.[24] However, dedicated obstetric airway guidelines have since been developed, and efforts have aimed to standardize difficult airway trolleys across maternity units.[25–27]

The multidisciplinary nature of emergency obstetric care adds further complexity. Obstetricians, midwives, neonatal teams, and theater staff converge in the operating room, often leading to a crowded, noisy, and chaotic environment.[28,29] This can disrupt team coordination, hinder communication, and delay the recognition or escalation of airway difficulties.[30,31]

Staff on the labor ward may be more accustomed to neuraxial anesthesia and less familiar with general anesthesia protocols, especially during obstetric emergencies. Junior anesthesiologists, often working out-of-hours, may have limited experience in obstetric GA, increasing the risk of error. The decreasing use of GA in obstetrics has contributed to this skills gap; while this trend has improved safety overall, it has reduced training opportunities for newer practitioners.[32–34]

Cognitive Load and Psychological Pressures

The psychological burden in obstetric airway management is significant. Anesthesiologists must manage the care of both mother and fetus. This dual responsibility, along with the association of obstetric general anesthesia with difficult intubation, may contribute to increased anxiety and self-doubt.[35]

High cognitive load during time-critical emergencies can impair decision-making,[22] leading to fixation errors, poor adherence to protocols, and delays in seeking help.[22,36]

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These challenges are amplified in unfamiliar environments,[37] particularly when several teams are involved with high-stakes outcomes.[30]

HUMAN FACTORS IN THE MANAGEMENT OF THE OBSTETRIC AIRWAY

Teamwork and Communication

Psychological safety and flattened hierarchies

Effective team performance in emergencies relies on creating psychological safety, a shared belief that team members can speak openly without fear of embarrassment or reprimand. This concept, first described by Edmondson,[23] highlights the importance of environments where individuals feel comfortable asking questions, offering suggestions, and drawing attention to potential errors. When psychological safety is present, team members are more likely to contribute their observations and concerns. This is essential for timely recognition of complications in critical situations, for example, the absence of a capnography trace following intubation.

In the operating theater, traditional hierarchical structures can impede open communication.[38] Flattening these hierarchies encourages all team members, from junior trainees to senior clinicians, to actively participate in discussions and decision-making processes.[39,40] One practical method to promote a flattened hierarchy is the use of first names among team members. This practice has been shown to reduce perceived power distances, making it easier for individuals to speak up and engage in critical conversations.[41–45]

Closed-loop communication

Closed-loop communication (CLC) is a structured method of information exchange designed to minimize misunderstandings, particularly in high-pressure clinical scenarios. It involves 3 key steps: the sender issues a clear instruction, the receiver repeats the instruction to confirm understanding, and the sender acknowledges the confirmation, ensuring the message was correctly received and interpreted.[46,47] Using CLC fosters a shared mental model among team members, promotes identification and correction of potential errors.[48] This is useful during management of the obstetric airway where quick and clear communication between team members is vital.

Role clarity

Role clarity allows team members to have a shared mental model, and an understanding of each other's role and responsibilities.[49,50] Structured team briefings before induction, especially in anticipated difficult airway scenarios, should assign specific roles such as the airway lead, drug administrator, and airway assistant. These briefings should also outline the airway plan and escalation pathway, as described in guidelines for managing difficult or failed intubations.[26]

Decision-Making Under Pressure

Standardization where possible

Standardizing routine anesthetic practices can reduce cognitive burden, especially in time-critical obstetric emergencies. Performance can suffer when an individual is expected to manage multiple tasks at once, particularly those with less experience.[51,52] Reducing the number of decisions that must be made under pressure can therefore help maintain performance.

One practical example is simplifying drug choices. While thiopental was once the preferred induction agent for obstetric general anesthesia, the NAP5 report found it was used in only 3% of general anesthetics but was associated with 23% of awareness cases.[53] This may be partly due to trainee inexperience with thiopental, as

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propofol is more commonly used across a range of anesthetic settings. These findings support the shift toward standardizing propofol as the default induction agent, helping to reduce variability and cognitive demand during high-pressure situations.

Standardization of hospital airway equipment is advised.[11] Implementing standardised protocols, such as using prefilled syringes and predetermined equipment sizes (eg, size 7 endotracheal tubes), can reduce cognitive load during emergencies. This reduced cognitive load may then decrease the likelihood of errors and enhance efficiency.

Flexibility where necessary

While standardization supports safety and efficiency, anesthesiologists must retain the flexibility to adapt to individual clinical scenarios. Maintaining the ability to assess each case on its own merits ensures patient-centered, responsive care. For example, while a rapid sequence induction for a category 1 caesarean is typically the fastest approach, a known or anticipated difficult airway may prompt the anesthesiologist to pursue an awake approach or neuraxial anesthesia instead.

Fixation errors and escalation planning

In high-pressure scenarios such as failed intubation, fixation errors can occur when clinicians focus narrowly on a single task, like repeated laryngoscopy attempts, while losing sight of broader clinical priorities, such as maintaining oxygenation. This type of cognitive tunnel vision contributed to the tragic death of Elaine Bromiley, where the team persisted with airway interventions despite falling oxygen saturations, ultimately failing to transition to a *can't intubate, can't oxygenate* (CICO) pathway in time.[54]

Assigning an airway assistant to monitor oxygen saturation and capnography helps maintain situational awareness and allows for timely recognition of deterioration. Use of structured management algorithms, such as the Obstetric Anaesthetists' Association/Difficult Airway Society (OAA/DAS) guidelines for managing the difficult and failed intubation in obstetrics, can help teams avoid fixation by clearly outlining escalation pathways. These guidelines recommend limiting intubation to 2 attempts, with a third attempt only by a more experienced anesthesiologist.[26] If intubation fails, up to 2 attempts can be made placing a supraglottic airway (SGA).[26] If oxygenation is adequate, consider waking the patient; if unable to oxygenate, proceed to front-of-neck access.[26] The OAA/DAS guidelines also provide a structured framework to support decision-making after failed intubation, helping clinicians decide whether to proceed with surgery or wake the patient.[26] This includes a table of weighted considerations across key factors: maternal and fetal condition, anesthetist experience, patient obesity, aspiration risk, availability of alternative anesthetic options, level of airway control, and presence of airway hazards.[26] These frameworks promote a shared mental model among team members, enabling more coordinated responses and timely transitions to alternative strategies when initial plans fail.

Anticipation and Situational Awareness

Early identification of high-risk airway and collaborative communication

Timely identification of patients at risk of airway difficulty is essential for safe obstetric anesthetic care. Individuals with obesity, limited neck mobility, preeclampsia, or a known history of difficult intubation should be assessed by anesthetists well in advance of potential emergencies. Ideally, these reviews take place during antenatal anesthetic clinics, where there is sufficient time to formulate an individualized airway plan and ensure necessary equipment is available.[55]

In the labor ward, anesthetists benefit from collaboration with midwifery and obstetric colleagues. Attendance at shift handovers, and huddles, facilitates early communication about high-risk cases, allowing anesthesia teams to review patients

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proactively rather than reactively. The Royal College of Anaesthetists emphasizes the importance of anesthetist involvement in multi-disciplinary team (MDT) delivery suite handovers and ward rounds to facilitate shared understanding and coordinated care.[56] This multidisciplinary approach can enhance preparedness and improve safety in time-critical scenarios.

Clinical airway assessment

Airway assessment is a vital component of the preanesthetic evaluation, aiming to anticipate potential difficulties with face mask ventilation, endotracheal intubation, and emergency front-of-neck access (eFONA). In obstetric anesthesia, this task is particularly important due to the unique anatomic and physiologic changes in pregnancy, which predispose patients to rapid oxygen desaturation, difficult airway management, and increased aspiration risk.[12–14,19] Traditionally, clinical prediction tools for airway assessment are based on bedside tests, including the Mallampati score, interincisor gap, thyromental and sternomental distances, neck mobility, and mandibular protrusion tests. These are simple and widely used but have limited sensitivity and specificity when used in isolation.[57]

Neck ultrasound for airway assessment

There is growing interest in the role of point-of-care ultrasound (POCUS) for airway assessment. Neck ultrasound has shown promise in identifying anatomic predictors of difficult laryngoscopy.[58,59] However, its utility is currently limited by the need for standardized training, operator experience, and validation of measurement thresholds specific to the obstetric population.[60] Neck ultrasound demonstrated greater accuracy in locating the cricothyroid membrane (CTM) compared to traditional palpation methods in obese parturients.[61] While routine use is not yet standard, ultrasound may soon have an established role in pre-induction CTM identification, potentially improving the safety and success of eFONA in emergency situations.

Intubation checklist use and preinduction pause

Checklists have been shown to improve performance in rare or stressful events.[62] NAP 4 issued an example checklist to complete in preparation for intubation in critical care.[11] The use of an intubation checklist could be considered in other areas where intubation may not be undertaken regularly, for example, in obstetric care. Structured checklists standardize preparation: drug availability, confirmation of suction, function of capnography, and presence of backup devices (SGA, bougie, and videolaryngoscope). A final preinduction pause conducted immediately before rapid sequence induction (RSI) ensures shared understanding of the airway strategy and contingency plans.

Planning for failure

Familiarity with the DAS guidelines prepares teams for managing difficult airways. Second-generation SGAs can function as rescue devices after failed intubation and are increasingly considered as primary airway tools in obstetric emergencies. In a series of 3000 elective CSs using second-generation SGAs, Halaseh and colleagues[63] reported only 1 regurgitation event and no aspirations, underscoring a high safety margin. Meta-analyses similarly demonstrate comparable rates of first-attempt success and adverse events SGAs and endotracheal tubes, although data are underpowered for definitive conclusions.[64] While many studies exclude high-risk women (eg, BMI >35 kg/m^2, severe reflux), the consistent performance of second-generation SGAs supports their early use to preserve oxygenation rather than persisting with repeated intubation attempts, in line with OAA/DAS guidelines.[26] Efforts to limit the risk of aspiration include: using a second generation SGA, an adequate level of

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anesthesia, continuing cricoid pressure throughout the surgery, and requesting the obstetrician to limit fundal pressure.[65]

When intubation, SGA ventilation, and bag-mask ventilation fail, a *CICO* scenario mandates eFONA.[26] The OAA/DAS obstetric airway algorithm specifies that eFONA should be performed without delay, necessitating regular hands-on training to maintain clinician proficiency.[26] Conversely, if oxygenation remains adequate and the risks of proceeding outweigh benefits, waking the patient is a viable alternative.[26] This option allows reconsideration of neuraxial techniques or reoptimization of GA.

Ergonomics and Environment

Theater layout and equipment access

A well-designed theater layout supports rapid access to airway equipment during emergencies. Positioning airway trolleys adjacent to the anesthetic workstation minimizes delays during time-critical events. Efforts have been made to standardize difficult airway trolleys, such as those promoted by the DAS, with the aim of ensuring familiarity across sites, reducing cognitive load, and improving efficiency under pressure.[25–27] The suction should be turned on and within reach, and the anesthesiologist should be positioned so they can easily see the monitor and access the reservoir bag.[65]

Noise and distractions

Distractions in the operating theater can interfere with communication, impair concentration, and increase the likelihood of error.[66] Sources include alarms, equipment, ventilation systems, and nonessential conversations. Anesthetic induction and emergence are high-risk periods that require focused attention. Adopting the *sterile cockpit* principle, borrowed from aviation, advocates for minimizing unnecessary dialogue and distractions during these phases.[67] Studies show that noise during caesarean deliveries frequently exceeds recommended safe levels, particularly during emergencies.[28,29] Anesthetists should assertively limit nonurgent communication during airway management to protect cognitive bandwidth and patient safety.

Patient positioning

Optimal positioning is essential for effective and safe airway management in obstetric anesthesia. The patient's head should be positioned at the very top of the operating table to allow full extension and access. At minimum, a standard pillow should be used; however, the Oxford Head-Elevated Laryngoscopy Pillow (Alma Medical, Oxford, UK) can facilitate an ideal *ramped* position, aligning the external auditory meatus with the sternal notch.[68] This position improves glottic view, maximizes FRC, and enhances preoxygenation.[69] Simultaneously, left uterine displacement is employed to mitigate aortocaval compression and maintain maternal hemodynamics.[70]

Optimizing First-Attempt Intubation

Adequate preoxygenation

Aim for end-tidal oxygen concentration $\geq$0.90 via tidal breathing of 100% oxygen by facemask at flows $\geq$10 L/min for 3 minutes.[26,71] This maximizes oxygen reserves, extends the time to desaturation during apnea, and provides the intubator a longer, safer window to secure the airway. High-flow nasal oxygen (HFNO) has also been used to preoxygenate patients, though limitations exist in capnography monitoring.[72]

Apnoeic oxygenation

Continuing to hold a tight-fitting face mask after preoxygenation can provide some oxygen during the apneic period.[73] Low-flow nasal cannulae at 5 to 15 L/min during laryngoscopy provide continuous oxygen delivery into the pharynx, promoting passive

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oxygen diffusion even in the absence of active ventilation.[74] This helps delay hypoxia and gives the intubator valuable additional time. Newer HFNO models are compatible with facemasks, allowing smooth transition to face mask ventilation and enabling capnography if needed, while also providing the advantages of warmed, humidified air.[75]

Gentle facemask ventilation

Controlled ventilation with airway pressures less than 20 cmH_2O after induction helps maintain oxygen saturation without significantly increasing the risk of gastric insufflation, in the presence of cricoid pressure.[76,77] This technique reduces early desaturation, particularly in high-risk or hypoxaemic patients,[78] thereby extending the safe apnea time and creating more favorable conditions for a successful first-pass intubation It also allows the anaesthetists to test circuit integrity early in airway management and provides confidence that the anesthesiologist can bag mask ventilate the patient if the intubation attempt is unsuccessful. NAP5 acknowledged the gap between intravenous induction of anesthesia and commencing volatile agents contributed to the risk of awareness,[53] earlier ventilation with volatile agents may reduce this gap and risk of awareness in difficult intubations.

Cricoid pressure

Apply 10 N in awake patients, increasing to 30 N postinduction, with readiness to release if it impedes glottic visualization or ventilation.[26,79] A small study described para-laryngeal pressure as noninferior to cricoid pressure and it avoids airway distortion, however, further study would be needed before this could be recommended as an alternative.[80]

Videolaryngoscopy

Video laryngoscopy (VL) is a valuable tool in airway management. Retrospectively Aziz and colleagues[81] demonstrated 100% first-pass success in 18 obstetric intubations using VL versus 96% with direct laryngoscopy (DL), with the failed DL attempt rescued by VL. In a randomized trial, the McGrath Series 5 VL was compared to the Macintosh DL in 80 elective caesarean patients: both achieved 100% first-attempt success, but VL provided superior glottic views without increasing complication rates.[82] VL achieves a better glottic view and is advantageous in the management of difficult airways.[35,83,84] The OAA/DAS and Prevention for the unrecognized esophageal intubation guidelines recommend VL availability and practitioner competence, citing its role in reducing unrecognized esophageal intubation.[26,85] Although meta-analyses reveal similar overall success rates, likely due to limited obstetric-specific data, the enhanced visualization and rescue capability of VL make it the preferred initial tool. Furthermore, VL allows a shared laryngoscopy view, facilitating assistance and a shared understanding of the stages of the procedure.

Mitigating Residual Risks

Aspiration prophylaxis

To lower the chance of aspiration pneumonitis, clinical guidelines advise that women undergoing a CS, or those at high risk of needing one, be given antacid medications to decrease both the volume and acidity of gastric contents.[86] Commonly, sodium citrate along with either an H2-receptor antagonist or a proton-pump inhibitor are prescribed as part of the protocol to reduce aspiration risk.[87,88]

Extubation planning

It has been recognized that one-third of major airway events occur during emergence and recovery.[11] Plan extubation for when the patient is fully awake with

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protective reflexes intact, ideally in a head-up position to improve airway access and respiratory function, especially in obese patients.[26,89] Full reversal of muscle relaxants is essential for airway muscle recovery.[90] Quantitative neuromuscular transmission monitoring is recommended to minimize the risk of residual neuromuscular blockade and reduce associated complications at the time of extubation.[91] This would be particularly useful in obstetric anesthesia due to the combination of the high dose muscle relaxant for intubation, relatively short surgery, and high aspiration risk. Specific guidelines are available for extubation of difficult airways.[92]

Training and Simulation

High-fidelity simulation

Simulation-based education plays a valuable role in developing and maintaining both technical and nontechnical skills relevant to obstetric airway management. The limited frequency of general anesthesia in obstetrics presents challenges in maintaining procedural competence, particularly for junior anesthetists. Simulation provides a safe environment to practice rarely used, yet vital, skills such as eFONA in *CICO* scenarios.[93]

Studies have demonstrated that simulation enhances trainee satisfaction, technical ability, and clinical performance.[94,95] High-fidelity simulations have been shown to improve nontechnical skills, including communication and decision-making.[96] Simulation integrated with proficiency-based progression further supports the acquisition of core obstetric anesthesia skills[97] and skills learned though simulation can be maintained long-term.[95] NAP4 highlighted the risks associated with reduced general anesthesia exposure in obstetrics and underscored the importance of continued training to sustain airway management proficiency.[11] Simulation, therefore, remains a vital tool for mitigating human factors in this high-stakes domain.

Multidisciplinary involvement

- Study Days and Workshops:

Interprofessional study days and workshops offer structured opportunities for shared learning across maternity disciplines. These sessions may focus on obstetric emergencies, updated guidelines, or clinical skills. The PROMPT programme is a widely adopted model combining simulation, lectures, and hands-on training. Its implementation has been linked to improved neonatal outcomes and safer obstetric care.[98]

- Multidisciplinary Labor Ward Handover and Ward Rounds:

Daily labor ward handovers and ward rounds involving anaesthetists, obstetricians, and midwives enhance communication, support joint decision-making, and promote coordinated patient management. The Royal College of Anesthetists (RCOA) highlights the importance of anesthetist involvement in these handovers (RCOA, 2021), which not only facilitates early identification of clinical concerns but also serves as a valuable opportunity for shared learning and interprofessional development within the multidisciplinary team.

- MDT Clinics and Meetings:

Structured MDT clinics and planning meetings are advised for managing pregnancies complicated by comorbidities.[99] These forums allow comprehensive discussions among relevant specialists, facilitating both planning and team learning.

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SUMMARY

The obstetric airway presents unique and well-recognized challenges. Pregnancy-related anatomic and physiologic changes contribute to airway edema, altered respiratory mechanics, and an increased risk of desaturation. These factors, combined with a higher incidence of difficult intubation and reduced functional reserve, make airway management in this population particularly complex. Time pressure and the need for rapid decision-making further compound these difficulties. Understanding the interplay of these challenges is essential in anticipating problems and planning appropriate strategies.

This article examined the challenges of the obstetric airway through the lens of human factors, highlighting how a better understanding of these concepts can inform safer clinical practice. Human factors provide a useful framework for analyzing the cognitive, social, and environmental elements that influence performance in high-pressure situations. In the context of the obstetric airway, they help explain why difficulties arise and how systems and teams can be better prepared. It is important for the anesthesiologist to be aware of these factors when managing the obstetric airway, particularly given the time-critical nature and emotional intensity of such scenarios. Recognizing and addressing these human factors can support more effective teamwork, decision-making, and preparation. By applying these principles to everyday practice and reinforcing them through training and multidisciplinary collaboration, we can begin to reduce risk and improve outcomes in this uniquely challenging area of anesthetic care.

CLINICS CARE POINTS

- Recognise obstetric patients as high-risk airway groups. Do not assume the same airway difficulty profile as non-obstetric patients and anticpate increased intubation failure risk.
- Expect rapid physiological decline. Pregnancy-related reductions in physiological reserve mean airway issues escalate quickly.
- Prioritise structured team communication. Stress and cognitive load can impair performance, clear communication pathways are essential during airway emergencies.

DISCLOSURE

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